

MARYLAND STATE DEPARTMENT OF HEALTH

241 N. Charles St., Baltimore

03915

183

CERTIFICATE OF DEATH

Reg. Dist. No.

93d

1. PLACE OF DEATH:

County.....

City or town.....

Hayford

Shawsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

ELIZABETH M. AMOS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white widow

6.(b) Name of husband or wife

Cosbie Amos

7. Birth date of deceased (mo., day, yr.)

Jan 19 - 1872

6.(c) If alive, give age - years

8. AGE:

Years

Months

Days

If less than one day

76 3 1 hrs. min.

9. Birthplace

Coftown, Hayford, Md.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

George W Morse

12. Name

Coftown Md.

13. Birthplace

Talora Green

14. Maiden name

Baltimore Md

15. Birthplace

Mrs Fred L Bell

16. Informant

White Hall Md

Address

Date thereof. Feb 22 - 48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Date (month) (day) (year)

Location

Coftown, Hayford, Md.

18. Funeral director

Martha E. Scott

Address

Garrettsoffle, Md.

Apr. 22

1948 Thomas P. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Hayford

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20 1948 at 5¹⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 5 1946 to April 20 1948

and that I last saw her alive on April 19 1948

Immediate cause of death

CEREBRAL THROMBOSIS

DURATION

22 hr.

Due to

1st attack CEREBRAL THROMBOSIS May 1948

Due to

Other conditions

Disease with hypertension

4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson M.D.

M. D. or other

Address Forest Hill, Md. Date signed 4/29/48

M
The correct age

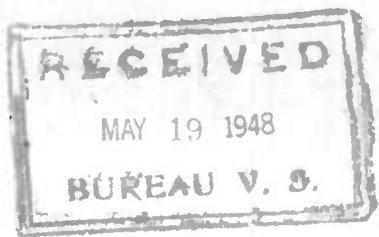
MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03916

182

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HARFORD

City or town RURAL - BEL AIR.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 MONTHS.

Hospital, institution, or street address where death occurred:

HARFORD CONVALESCENT HOME

How long in hospital or institution? 9 MONTHS

3. (a) FULL NAME

DANIEL THOMPSON ASBURY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWED.

6. (b) Name of husband or wife

ASBURY

NANNIE ELIZABETH

7. Birth date of deceased (mo., day, yr.)

16 DEC 1867

DECEASED

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

TAZEWELL CO. VIRGINIA

(Town, county, and state)

10. Usual occupation

RETIRED FARMER

11. Industry or business

—

MOTHER FATHER

12. Name

JOHN ASBURY

13. Birthplace

TAZEWELL CO., VA.

14. Maiden name

EMILY BRINEGER

15. Birthplace

TAZEWELL CO., VA.

16. Informant

KELLY ASBURY

Address

DELTA, PA.

17. BURIAL

Date thereof APR. 16 '48

(Burial, cremation, or removal. Which?)

Cemetery or

HIGHLAND

Location

STREET, MD.

18. Funeral director

HUBERT P. HARKINS

Address

DELTA, PA.

19.

Date rec'd by registrar

April 15, 48 M. V. Kirk

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County YORK.

City or town DELTA, PA.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (b) Social Security Number —

MEDICAL CERTIFICATION

20. DATE OF DEATH

APRIL 14 1948 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 APRIL 1948 to 14 APRIL 1948

and that I last saw him alive on 13 APRIL 1948

Immediate cause of death

HYPOSTATIC PNEUMONIA

DURATION

2 DAYS

Due to CONGESTIVE HEART FAILURE

ARTERIOSCLEROSIS (ADVANCED)

6 DAYS

Due to Other conditions

7 YEARS

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide —

Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —

Means of injury

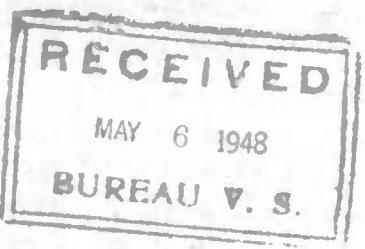
—

Injured at work? —

23. SIGNATURE

M. D. or other

H. P. Sidwell M.D.
Bel Air, Md. Date signed April 15, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03917

Reg. Dist. No. 182

CERTIFICATE OF DEATH

85

1. PLACE OF DEATH:

County..... *Hartford*City or town..... *Forest Hill* Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... *hope*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles L Ayres

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*M**W**S*

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug 16 - 1941

8. AGE: Years Months Days If less than one day

*7*9. Birthplace..... *Forest Hill, Md.*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... *Ulysses Grant Ayres*13. Birthplace..... *Rockville, Md*14. Maiden name..... *Ruth ANNE Martin*15. Birthplace..... *Hartford Co., Md*16. Informant..... *Mr. U. Grant Ayres*Address..... *Forest Hill, Md*17. Burial..... *Burial*
(Burial, cremation, or removal. Which?)Date thereof..... *April 17/48*
(month) (day) (year)Cemetery or crematory..... *St Ignatius*Location..... *Hickory, Md*18. Funeral director..... *Joseph J. Salter*Address..... *Bel Air Md*19. *4/16*..... *1978 P forward*
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md County..... *Hartford*

City or town.....

Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 15 1948, at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1948 to April 14 1948
and shall last saw him alive on April 14 1948

Immediate cause of death.....

Epilepsy, Idiopathic

DURATION

7 years

Due to..... unknown

Due to.....

Other conditions.....

Mental deficiency 7 years

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

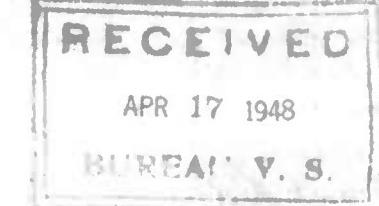
Robert Barthol
M.D.
Forest Hill, Maryland

M. D. or other

4/15/48

Address.....

Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03918

Reg. Dist. No.

181

CERTIFICATE OF DEATH

159

1. PLACE OF DEATH: Harford
 County: _____
 City or town: RURAL - Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? $\frac{1}{2}$ hour

Hospital, institution, or street address where death occurred:
 Shack on Liverzey Farm, near Aberdeen

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy Biggs (No given name)

4. Sex: Male

5. Color or race: Negro

6. (d) Single, married, widowed, or divorced: Single

6. (b) Name of husband or wife: (None)

7. Birth date of deceased (mo. day yr.) April 11, 1948

8. AGE: Years: _____ Months: _____ Days: _____ If less than one day: 1 hrs: _____ min: _____

9. Birthplace: Aberdeen, Harford, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

MOTHER FATHER: Mother 2 weeks there was no father!!!

13. Birthplace: Aberdeen, Md.

14. Maiden name: Mary Elizabeth Biggs

15. Birthplace: Aberdeen, Md.

16. Informant: James D. Biggs (Grandfather)

Address: Liverzey Farm, Aberdeen, Md.

17. Burial: Buried Date thereof: April 12, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or crematory: Buried in woods on

Location: Liverzey Farm, Aberdeen, Md.

18. Funeral director: None! Buried by J.D. Biggs

Address: _____

19. Date rec'd by registrar: Apr. 15 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Harford

City or town: Aberdeen - RURAL
 (If outside city or town limits, write RURAL and give nearest town)

Street No.: Liverzey Farm, Aberdeen (Mt. Royal Ave.)

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1948, at 8:30 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from (Never saw baby alive) 19...

and that I last saw him alive on 19...

Immediate cause of death: Prematurity

Due to: Not known but ap - parently natural cause

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury: _____

Injured at work? _____

23. SIGNATURE: _____

Loddyay, Jr. M.D. or other _____
 Address: Belair + Purple Aberdeen, Md. signed 4/13/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03919

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....

Harford

City or town.....

Harford Co., near Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

JAMES WINFRED BULL

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife.....

Ruth Palmer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug 4-1908

8. AGE: Years

39

Months

Days

If less than one day

..... hrs. min.

9. Birthplace.....

Emmorton, Md
(Town, county, and state)

10. Usual occupation.....

Merchant

11. Industry or business

12. Name..... Robert L. Bull Sr

13. Birthplace

Md

14. Maiden name..... Alice L. Scatter

15. Birthplace

Md

16. Informant..... Mrs. James W. Bull

Address..... 3701 Nortonia, Baltimore 16/ Md
Date thereof..... April 7/48

(Month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Rock Spring

Location..... Forest Hill, Md.

18. Funeral director..... Joseph T. Foster

Address..... Bel Air, Md

19. 4/6 78 8th Street
(Date rec'd by registrar) 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3701 Nortonia

(If rural, give LOCATION)

2.(a) If veteran, name war..... War. S. War (2)

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 8

1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Fracture of skull
Compound fracture

Due to..... Rd leg

Fracture of left leg.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... April 4/48
Where did injury occur?..... near Churchville Harford and (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Near airfield

Means of injury..... Airplane Crash Injured at work? No

23. SIGNATURE.....

John Lawrence M.D.
Deputy Medical Examiner
Aberdeen, Md Date signed 4/4/48

Address.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03920

CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH:

County

Harford

City or town

Rural

Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bates G Burt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

E. May Burt

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 21, 1878

8. AGE:

Years

Months

Days

If less than one day
hrs. min.

69

3

14

9. Birthplace

Wheeling W. Va.

(Town, county, and state)

10. Usual occupation

Telegrapher

11. Industry or business

Mason W. Burt

12. Name

Mass.

13. Birthplace

Abing st. Bates

14. Maiden name

Mass.

15. Birthplace

Mass.

16. Informant

Mrs. William Norrell

Address

Redwood Md.

17. Cremation

Date thereof Apr 8 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore Maryland

18. Funeral director

Howard R. McCormick

Address

Abingdon Maryland

19. Date rec'd by registrar

Apr 8 1948

(Date rec'd by registrar)

18

7

Marie M. Mulsdale

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Rural

Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Emmorton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 5

1948, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

On April 5 1948 Only

19

and that I last saw him alive on April 5

1948

Immediate cause of death

pulmonary Edema (Acute Congestive Heart Failure)

DURATION

6 hrs?

Due to

Terminating a Coronary Thrombosis

(4/4/48)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson M.D.

M. D. or other

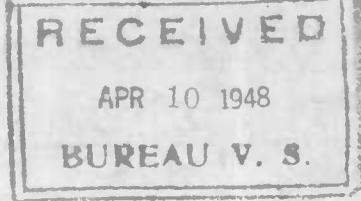
Address

Forest Hill Md.

Date signed

4/7/48

M. McCorm



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03921

182

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Harford
City or town..... Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Franklin Cathcart

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

B. (b) Name of husband or wife

Amanda C Battens

7. Birth date of deceased (mo., day, yr.)

Dec 19/1864

B. (c) If alive, give age years

8. AGE:

83

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Harford

(Town, county, and state)

10. Usual occupation

Patient

11. Industry or business

12. Name

Wm Cathcart

13. Birthplace

Md

14. Maiden name

Jane Cathcart

15. Birthplace

Md

16. Informant

Nelson Kyler

Address

Fallston, Md

17. Burial

BurialDate Thereof April 22/48

(month) (day) (year)

Cemetery or crematory

Bethel Presbyterian

Location

Harford Co - Md

18. Funeral director

Joseph T. Palmer

Address

Bethel, Md

19. Date rec'd by registrar

4/211948 P forward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Fallston (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 20 48 at 10⁵⁵ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1 1940 to April 20 1948and that I last saw h...I.M. alive on April 20 1948

Immediate cause of death

Anteriorisclerotic
CV Disease

DURATION

8 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Gerald C Palmer M.D.

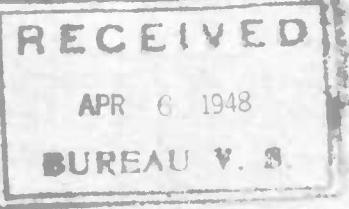
M. D. or other

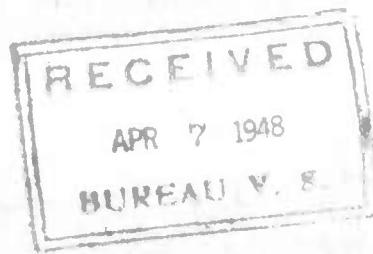
Address Bel Air, Md Date signed 4/21/48

RECEIVED

APR 23 1948

BUREAU V. S.





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03924

185-

q3d
Reg. Dist. No.

CERTIFICATE OF DEATH

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County..... Hanford
 City or town..... Hare de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hanford Memorial Hospital

How long in hospital or institution?

5 1/2 mos.

3. (a) FULL NAME Mrs. Margaret Davis

4. Sex F. 5. Color or race W. 6. (a) Single married widowed, or divorced

6. (b) Name of husband or wife Mr. Edwin Davis

7. Birth date of deceased (mo., day, yr.) Mar. 13 - 1901 6. (c) If alive, give age 68 years

8. AGE: Years 47 Months - Days 23 If less than one day hrs. min.

9. Birthplace Hare de Grace (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER
12. Name M. P. Boyd

13. Birthplace Hare de Grace

14. Maiden name Margaret Connor

15. Birthplace Po.

16. Informant Edwin W. Davis

Address St. Clair & Washington, Hare de Grace

17. Burial Date thereof 4/8/48 (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory Mr. Cem

Location Hare de Grace

18. Funeral director Gemmington & Son

Address Hare de Grace

19. Apr. 6 19. 48 A. L. Lewis M.D.
(Date rec'd by registrar) (Date signed)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Hanford

City or town Hare de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 601 Oregon St.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1948 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 - 1947, 19, to April 5, 1948, and that I last saw her alive on April 4-48, 19.

Immediate cause of death Obstetric myocarditis DURATION

Due to Hypertensive CVD

Due to a recurrent vascular crises
+ cerebral hemorrhage

Other conditions Right hemiplegia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera M.D. M. D. or other

Address Hospital - Hare de Grace Date signed 4-5-48

RECEIVED

APR 9 1948

BUREAU U. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03925

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: HartfordCounty NelviaCity or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Divers4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Mar 28 - 18678. AGE: Years 81 Months Days If less than one dayhrs. min. 9. Birthplace Upper Cross Rds Hartford Co., Md

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name ANNINIAS Divers13. Birthplace Md14. Maiden name Mary Jones15. Birthplace Md16. Informant Mrs Mary DiversAddress Benson, Md

17. Burial

(Burial, cremation, or removal. Which?) At Providence MethodistDate thereof Apr 14/48
(month) (day) (year)

Cemetery or crematory

Location Upper Cross Rds18. Funeral director Joseph T FosterAddress Bellair, Md19. 4/219. 48 P^o Fowood

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty HartfordCity or town Benson (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 1-1 - 1948, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6 - 1948 to April 1 - 1948and that I last saw h.m. alive on March 22 - 1948Immediate cause of death Arterio-sclerotic Cardiac disease

DURATION

Due to Senile change

unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

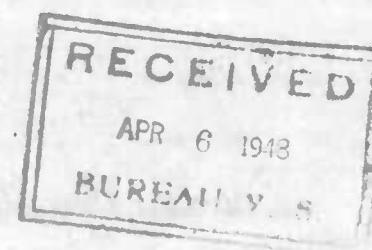
Injured at work?

23. SIGNATURE

J. F. Van Bibber

M. D. or other

Address Bel Air, Md. Date signed April 24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03926
93d
182

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County **Harford**
 City or town. **Wilmington** Rural
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **2 Yrs. 6 Mos.**
 Hospital, institution, or street address where death occurred:
Walters Nursing Home
 How long in hospital or institution? **2 Yrs. 6 Mos.**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State. **Md.** County. **Cecil**
 City or town. **Perryville** Md.
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME
Rebecca Evans

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced			
Female	White	Married			
8.(b) Name of husband or wife. William E. Evans					
7. Birth date of deceased (mo. day, yr.) June 10, 1876					
6.(c) If alive, give age. 69 years					
8. AGE:	Years	Months	Days	It less than one day	
71	9	28		hrs.	min.
9. Birthplace. Loreley, Balto. Co., Md. <small>(Town, county, and state)</small>					
10. Usual occupation. House Wife					
11. Industry or business					
MOTHER FATHER	12. Name. John B. Pensel				
	13. Birthplace. Baltimore Co., Md.				
MOTHER FATHER	14. Maiden name. Annie B. Knight				
	15. Birthplace. Baltimore Co., Md.				
16. Informant. Louise Owens					
Address. Perryville, Md.					
17. Burial. Burial <small>(Burial, cremation, or removal. Which?)</small> Cemetery or crematory. Asbury			Date thereof. April 9, 1948 <small>(month) (day) (year)</small>		
Location. Port Deposit, Md. Rural					
18. Funeral director. Lewa Patterson & Son					
Address. Perryville, Md.					
19. Date rec'd by registrar. April 8, 1948 M. W. Kirk					
			Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH. **April 7** 1948 at 6:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1948 to April 6 1948 and that I last saw her alive on April 6 1948.

Immediate cause of death. **Cerebral Hemorrhage**

Duration. **11 days**

Due to. **Hypertensive cardiovascular disease.** Unknown

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

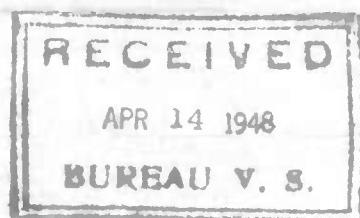
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE. **Robert Barthol MD.**
 Forest Hill, Maryland. M. D. or other
 Address. Date signed. **4/7/48**



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 47d+

03922
185

1. PLACE OF DEATH:

County Harford
 City or town Hawke de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

19 days

3. (a) FULL NAME

ANNIE T. FITZPATRICK

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 15, 1859

6.(c) If alive, give age years

8. AGE: Years

88

Months

4

Days

10

If less than one day

hrs.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Unknown

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mrs. Charles King,
Van Bibber, Harford Co.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr. 29, 1948
(month) (day) (year)

Cemetery or crematory

St. Francis

Location

Abingdon Md.

18. Funeral director

Howard K. McComas & Son

Address

Abingdon Md.

May 3 1948

(Date record by registrar)

A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Harford
Van Bibber

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 April 1948 at 115 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 April 1948 to 25 April 1948and that I last saw her alive on 25 April 1948

Immediate cause of death

Respiratory failure

Due to

Pulmonary edema

Due to

Cardiac decompensation

Other conditions

Probable carcinomaleft lung

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Verneet M.D.

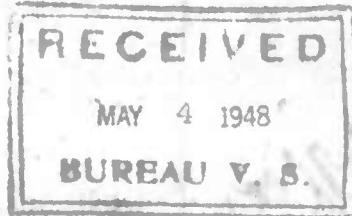
M. D. or other

Address

Harford Memorial Hosp
Hawke de Grace

Date signed

25 April 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03928

Reg. Dist. No.

183

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

Harford
Street

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

42 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Widower

Ella Devoe

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age.....years

72

11

9

hrs. min.

8. AGE: Years Months Days If less than one day

Rocke Harford Co Md

(Town, County, and state)

9. Birthplace.....

Farmer

10. Usual occupation.....

James Wilson Gladden

Rocks Md

Blanche Richardson

Rocks Md

Charles Gladden

Street Md.

Burial

Highland

Street

Marshall Clark

Jarrettsville Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory.....

Location.....

Means of injury.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

1948 Thomas R. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Harford

City or town.....

Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 6,

1948

at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April

1947

to April 6,

1948

and that I last saw h.t.b. alive on April 2,

1948

1948

Immediate cause of death.....

Cerebral

hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Charles C. Daff M.D.

M.D. or other

Address.....

Street, Md.

Date signed.

RECEIVED
MAY 11 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03929

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County: Harford
 City or town: Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 9 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md County: Harford
 City or town: Havre de Grace P.O. #2
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (a) FULL NAME
Mrs. Bessie E. Gorrell

3. (b) Social Security Number
220-22-0569

4. Sex: Female 5. Color or race: White 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Percy H. Gorrell

7. Birth date of deceased (mo., day, yr.): July 24, 1893 6.(c) If alive, give age: _____ years

8. AGE: Years: 54 Months: 8 Days: 18 If less than one day: - hrs: - min: -

9. Birthplace: Ta (Town, county, and state)

10. Usual occupation: House Duties

11. Industry or business: Floyd B. Alpert

12. Name: Floyd B. Alpert

13. Birthplace: Ta

14. Maiden name: Alberta May Tamm

15. Birthplace: Ta

16. Informant: Mrs. Minnie J. Gorrell

Address: Havre de Grace, Md. P.O. #2

17. Burial: Burial Date thereof: Apr. 14, 1948
 (Burial, cremation, or removal, which?) Date (month) (day) (year)

Cemetery or crematory: Tock Run

Location: Harford Co. Md.

18. Funeral director: J. Madison Mitchell

Address: Havre de Grace, Md.

19. Date rec'd by registrar: April 13, 1948 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH: April 11th 48 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 4/48 19 to April 11, 1948 19

and that I last saw her alive on April 11, 1948 19

Immediate cause of death: Terminal cancerous DURATION

Cachexia

Due to: Carcinoma of uterus

with extensive pelvic

Due to: invasion

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur: _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: _____ Injured at work? _____

23. SIGNATURE: John F. Noguera MD M. D. or other: _____

Address: Hospital - H. de Grace Date signed: 4/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46+

03930

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County: Harford
 City or town: Rural - Whiteford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred: Home - Whiteford, Md.
 How long in hospital or institution?

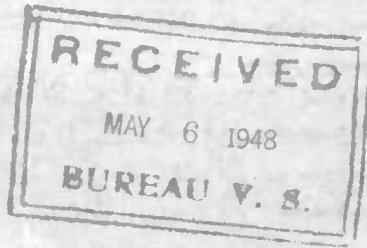
2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Harford
 City or town: Rural - Whiteford (Md.)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: _____
 (If rural, give LOCATION)

3. (a) FULL NAME: Minnie Ellen Ingram
 4. Sex: Female Color or race: White Marital status: Married
 6. (a) Name of husband or wife: Paul Landreth Ingram
 7. Birth date of deceased (mo., day, yr.): April 19, 1903
 8. AGE: Years: 45 Months: 0 Days: 3 If less than one day: — hrs: — min: —
 9. Birthplace: Ash County - North Carolina
 (Town, county and state)
 10. Usual occupation: Housewife
 11. Industry or business: _____
 MOTHER FATHER
 12. Name: John Burr Mahaffey
 13. Birthplace: Wilkes Co. N.C.
 14. Maiden name: Mary Frances Johnson
 15. Birthplace: Ash Co. N.C.
 16. Informant: Husband - Paul L. Ingram
 Address: Whiteford, Md.
 Date thereof: April 26, 1948
 (Burial, cremation, or removal, which?) Cemetery or crematory: Darlington, Md.
 Location: Harford Co. Md.
 18. Funeral director: H. D. Bailey
 Address: Darlington, Md.
 19. Date rec'd by registrar: April 29, 1948 M. D. Kirk
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1948 at 12:35 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948, to April 23, 1948, and that I last saw her alive on April 22, 1948.
 Immediate cause of death: CARCINOMA OF THE GALL BLADDER
 DURATION: 16 months
 Due to: _____
 Due to: _____
 Other conditions: _____
 (Include pregnancy within 8 months of death)
 Major findings or operations: _____ Date of op.: _____
 Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: _____ Date of: _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE: Charles A. Neff M.D.
 M. D. or other _____
 Address: St. Peter's, Md. Date signed: 4-23-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

03921
50X

1. PLACE OF DEATH:

County..... *Harford* RuralCity or town..... *Fairfaxton* (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *1 mo.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence Magness

4. Sex

Female white married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

Robert Lee Magness

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Apr 19 - 1876

8. AGE:

Years
72

Months

Days
7

If less than one day

hrs.
*.*min.
.

9. Birthplace.....

Harford Co Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER / FATHER

12. Name.....

John Winkler

13. Birthplace

Germany

14. Maiden name.....

Christine Smith

15. Birthplace

Germany

16. Informant.....

Mrs Mildred Preston

Address

Fairfaxton Md

17. Burial

(Burial, cremation, or removal Which?)

Date thereof..... *Apr 30 - 1948*
(month) (day) (year)

Cemetery or crematory

Mt Carmel Methodist

Location

Emmorton Md

18. Funeral director.....

Robert Archer

Address

Benson Md

19. (Date rec'd by registrar)

4/28/48

19.

P Forwood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Harford*City or town..... *Bell Air* (If outside city or town limits, write RURAL and give nearest town)Street No..... *R. F. D.* (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 28 1948, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1948 to April 27 1948,

and that I last saw her alive on April 27 1948.

Immediate cause of death..... *Carcinoma left breast with metastases.*DURATION
2 years.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

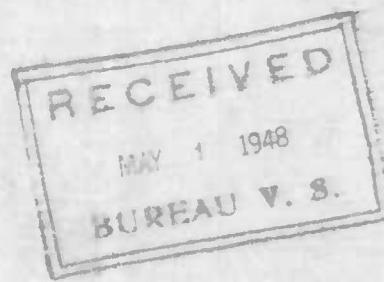
Injured at work?

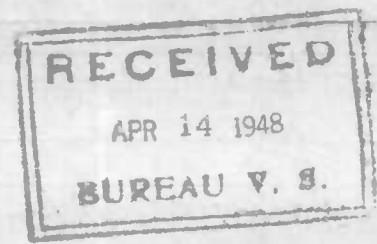
23. SIGNATURE.....

Robert Barthol M.D.

M. D. or other

Address..... *Forest Hill, Maryland* Date signed *4/28/48*





PLEASE WRITE PLAINLY, WITH
UNFADING INK. Every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Hartford
 County
 City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

3. (a) FULL NAME

Thomas Treanus McLane

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>W</u>
-----------------	---------------------------	---

6. (b) Name of husband or wife Winifred Clark

7. Birth date of deceased (mo., day, yr.) Dec 21 - 1879
 6. (c) If alive, give age years

8. AGE: Years 68 Months _____ Days _____ If less than one day _____
 hrs. _____ min. _____

9. Birthplace Clinton, Iowa
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
 12. Name Richard McLane
 13. Birthplace N.Y.

MOTHER
 14. Maiden name Elizabeth Jackson
 15. Birthplace Iowa

16. Informant Mrs. J. Norman Ambrosia
 Address Edgewood Md

17. Burial Date thereof April 19 / 48
(Burial, cremation, or removal. Which?)
 Cemetery or crematory Calvary Cemetery

Location Clinton, Iowa

18. Funeral director Jos T. Foster
 Address Bethel Md

19. 4/15 1948 P. forwarded
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Hartford
 City or town Edgewood, Md
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1948 to April 15 1948
 and that I last saw him alive on April 14 1948

Immediate cause of death Cerebral thrombosis DURATION 4-12-48

Due to Arteriosclerosis Years Years

Due to

Other conditions Myocarditis with hypertension and cardiac hypertrophy Years
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

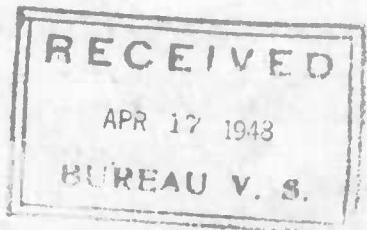
Means of injury

Injured at work?

23. SIGNATURE Fred O Hodson, M.D.

M. D. or other

Address Edgewood, Md Date signed 4-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03934

Reg. Dist. No. 185

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Elmer P. Meredith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

6. (b) Name of husband or wife

Elmer P. Meredith (deceased)

7. Birth date of deceased (mo., day, yr.)

Dec. 25 1859

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

88

3

15-

hrs.

mto.

9. Birthplace

South Hampton, L.I.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

Wm. S. Griffin

13. Birthplace

England

14. Maiden name

Sarah P. Brown

15. Birthplace

South Hampton, L.I.

16. Informant

Mrs. John T. Evans

17. Address

453 Queen St., Hanover Square

Burm

(Burial, cremation, or removal. Which?)

Date thereof 8/11/48

(month) (day) (year)

Cemetery or crematory

Engel Hill

Location

Hanover Square

18. Funeral director

Pennington & Son

Address

Hanover Square, Md.

Apr. 10 1948

(Date rec'd by registrar)

G. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

83a

Reg. Dist. No. 185

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 9 1948 at 7:17

21. I CERTIFY that death occurred on the date above stated; that the deceased from

July 3 1949 to April 9 1948
and that I last saw him alive on April 8 1948

Immediate cause of death

Cerebral Hemorrhage

Arterio Sclerosis

Hypertension

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed

RECEIVED

APR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03935
183

Reg. Dist. No. 183

1. PLACE OF DEATH:

County

Harford
White Hall R.T.D.

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edward Everett Moffitt

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white single

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) April 23 1974

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day hrs. min.

71 11 21

9. Birthplace Baltimore City

(Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business

12. Name George W. Moffit

13. Birthplace Baltimore, Md

14. Maiden name Mary Jane Wilson

15. Birthplace Baltimore, Md

16. Informant Mrs. Ella M. Aronson

Address 2852 Greenwich Ave

17. Burial Date thereof April 16-1974

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Beechwood

Location White Hall, R.T.D.

18. Funeral director Howard S. Marklin

Address White Hall, Md

19. Date rec'd by registrar Apr. 16 1948 Thomas P. Brown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town White Hall, R.T.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1948 at 12¹⁵ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 to Apr. 16 1948

and that I last saw him alive on Apr. 16 1948

1948

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

Generalized Arteritis -

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

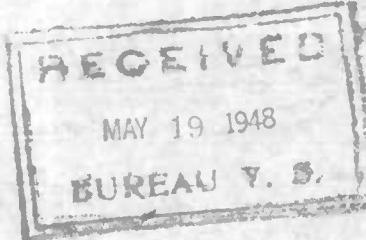
Means of injury

Injured at work?

23. SIGNATURE

M. D. *Frances*

Address Gardston, Md Date signed Apr. 17 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03936

CERTIFICATE OF DEATH

117a
Reg. Dist. No.

18/

1. PLACE OF DEATH:

County.....

Harford

City or town.....

Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

46 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William HENRY PRESBURY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male Colored married

6. (b) Name of husband or wife.....

*Clara M. Parker*6. (c) If alive, give age *45* years

7. Birth date of deceased (mo., day, yr.)

July 5 - 1901

8. AGE:

Years

Months

Days

If less than one day

*46**9**.....hrs.min.*

9. Birthplace.....

Aberdeen Harford Co. Md.

(Town, county and state)

10. Usual occupation.....

Day Labour

11. Industry or business

12. Name.....

Nelson Presbury

13. Birthplace.....

N. J.

14. Maiden name.....

Elinor Brooks

15. Birthplace.....

Aberdeen Md.

16. Informant.....

Mrs. William H. Presbury

Address

Aberdeen Md.

17. Burial.....

Date thereof *April 19 - 1948*
(Burial, cremation, or removal, Which?)
(month) (day) (year)

Cemetery or crematory.....

Mt. Calvary

Location.....

Near Aberdeen Md.

18. Funeral director.....

Bengell Tanning Sons

Address

Aberdeen Md.

19. Date rec'd by registrar

*Apr. 19**19 48**Nellie H. Riley*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Harford

City or town.....

Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Bush Chapel road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

*217-05-7710**approx*

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 15**19 48 at 10 P M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h.....alive on

19.....

Immediate cause of death.....

Portable Ruptured Gastric Ulcer with Massive Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

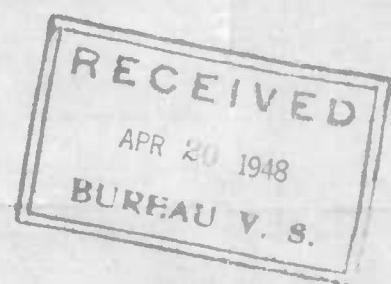
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE *Joe Lawrence M.D.**Baltimore County Medical Examiner*Address *Oxford Street*Date signed *4/17/48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03937

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

City or town..... *HARFORD*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HARFORD Mem. Hos.

How long in hospital or institution?

3. (a) FULL NAME

GEORGE PARKER

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Mildred

7. Birth date of deceased (mo., day, yr.)

July 29 1904

6.(c) If alive, give age..... 44 years

8. AGE:

Years
*43*Months
*9*Days
*15*11 less than one day
— hrs. — min.9. Birthplace..... *Durham, Penna.*

(Town, county, and state)

10. Usual occupation..... *Farm overseer.*

11. Industry or business

12. Name..... *Harvey Riegel*13. Birthplace..... *Bucks County, Pa.*14. Maiden name..... *Anna Mae Nicholas*15. Birthplace..... *Northampton County, Pa.*16. Informant..... *Clarence Riegel*Address *717. Court St. Nashville, Tenn.*

17. Burial /

(Burial, cremation, or removal. Which?)

Date thereof..... *Apr. 18/48*

(month) (day) (year)

Cemetery or crematory..... *Durham CEMETERY*Location..... *Durham, Penna.*18. Funeral director..... *ROBERT A. STRUTHERS*Address..... *Easton Rd. RIEGELSVILLE, Pa.*19. *Apr. 15-48* (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland*

County.....

*Baltimore*City or town..... *REISTER TOWN RD 1*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... *No**RIEGEL*

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 14*

1948, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

end that I last saw h.....alive on

19.....

Immediate cause of death.....

*Sut - Arachnoid and Subdural**Hemorrhage - Multiple Intracerebral**Due to Hemorrhages - Contusion + Laceration**Lower lobe Rt Lung - Bilateral**Burst Hemothorax*Other conditions..... *Terminal perforating Stomach Ulcer*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... *as above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

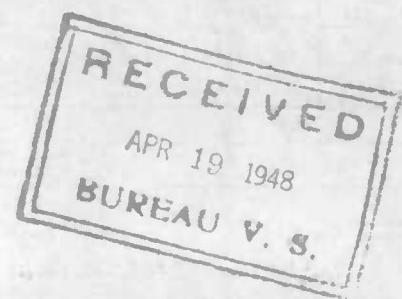
Accident, suicide, or homicide..... *Accident*Date of *April 13, 1948*Where did injury occur? *Belcamp Harford Md.*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Route #40*Means of Injury *Auto accident* Injured at work? *No*23. SIGNATURE..... *J. Hansen M.D.*Deputy Medical Examiner *John J. Hansen*

M. D. or other

Address..... *Oberdean Rd*Date signed *April 15, 1948*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03938

CERTIFICATE OF DEATH

Reg. Diat. No.

182

186a

1. PLACE OF DEATH:

County.....

City or town.....

*Harford
Bel-Air Rural
Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *1 mo*

3. (a) FULL NAME

Sarah Swift

4. Sex

(5) Color or race

(6) Single, married, widowed, or divorced

*Female White Widow
Benjamin Swift*

5. (b) Name of husband or wife

6. Birth date of deceased (mo., day, yr.)

7. AGE: Years

Months

Days

(e) If alive, give age years

85 / 8

it less than one day

hrs. min.

8. Birthplace

(Town, county, and state)

9. Usual occupation

10. Industry or business

MOTHER FATHER

11. Name

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

(Burial, removal, or removal of body)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date rec'd by registrar

I MARGIN RESERVED FOR BINDING
Please WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly.
 is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns infants give residence of mother)

State.....

County.....

City or town.....

*Md
Harford
Bel-Air
Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28 1948 to April 22 1948

and that I last saw her alive on April 22 1948

Immediate cause of death

Pulmonary Embolus

DURATION

Immediate

Due to Fracture, Right Hip

5 weeks

Due to

Other conditions Decubitus Ulcer, Sacrum

3 weeks

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

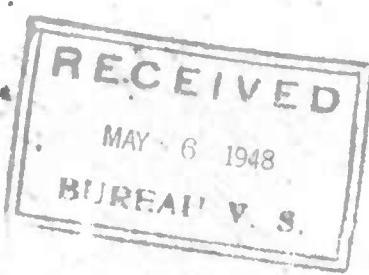
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. *acc.* Date of *acc.* 1948Where did injury occur? *Dublin - Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Church steps*Means of injury *Fall of steps* Injured at work?

23. SIGNATURE

M. D. or other *Robert Barthol MD*Address *Forest Hill, Md.* Date signed *4/23/48*

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03939

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH
 County Baltimore
 City or town Benson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD County Hanford
 City or town Rural Bellair
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 71 Benson
 (If rural, give LOCATION)

3. (a) FULL NAME Maryanna Tilley
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married
Elijah H Tilley
 6. (b) Name of husband or wife Elijah H Tilley
 7. Birth date of deceased (mo., day, yr.) July 27, 1883 6. (c) If alive, give age years
 8. AGE: Years 64 Months 3 Days 29 If less than one day
 hrs. min.
 9. Birthplace Ash County NC (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 MOTHER FATHER
 12. Name Alex Dixie
 13. Birthplace NC
 14. Maiden name Cynthia Gamble
 15. Birthplace NC
 16. Informant Robert Tilley
 Address Benson MD
 17. Burial Date thereof 4/27/48 (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory Centre
 Location Forest Hill MD
 18. Funeral director Gas E Gross
 Address Benson MD
 19. (Date rec'd by registrar) 7/26 1948 P. Towood

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1948 at 12 45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 1945 to April 24 1948
 and that I last saw her alive on April 24 1948
 Immediate cause of death Coronary Thrombosis DURATION 11 days
 Due to Terminating
 Due to Hypertensive Cardio-Vascular Disease 4 yrs
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
 Address Forest Hill MD Date signed 4/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03940

93d Reg. Dist. No. 181

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County HARFORD

City or town MAGNOLIA (RURAL)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 YEARS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

AGNES WATERS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female colored married
Ann M. Waters

6.(b) Name of husband or wife

6.(c) If alive, give age years

abt 1873

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Cal. Co. md

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

Lumber

12. Name

Lish

MOTHER FATHER

13. Birthplace

Elizabethtown

14. Maiden name

Brown

15. Birthplace

md

16. Informant

William H. Waters

Address

magnolia. md

17. (Burial, cremation, or removal. Which?)

Burial Date thereof May 3-48

(month)

(day)

(year)

Cemetery or crematory

Mt Auburn

Location

18. Funeral director

James A. Waters

Address

143 W. Will St

19. (Date rec'd by registrar)

Apr. 30 1948

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State HARFORD County HARFORD

City or town Magnolia (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/27 1948 to 4/29 1948

and that I last saw h.E.R. alive on 4/29 1948

Immediate cause of death CONGESTIVE HEART

FAILURE

DURATION

3 DAYS

Due to HYPER TENSIVE CARDIO-VASCULAR

DISEASE

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Stewart Jr., M.D.

M. D. or other

Address EDGEWOOD, MD.

Date signed

4/29/48

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03941

CERTIFICATE OF DEATH

52 ax
Reg. Dist. No.

182

1. PLACE OF DEATH:

County HartfordCity or town Baltimore, Md. General Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 10 days

3. (a) FULL NAME

Julia G

Wilson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6.(a) Single, married, widowed, or divorced

W

6.(b) Name of husband or wife

J Paul Wilson

7. Birth date of deceased (mo., day, yr.)

July 7-1890

6.(c) If alive, give age.....years

8. AGE:

Years
77

Months

Days

If less than one day

....hrs.min.

8. Birthplace

Hartford Co., Md

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Will Thomas Billings, Inc

MOTHER FATHER

12. Name

Mary Thomas Billings, Inc

13. Birthplace

Md

14. Maiden name

Mary A. G. Hart

15. Birthplace

Md

16. Informant

Dr Glenn Sutzyk

Address

Bel Air Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....April 16/48
(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

Fairfax Green

18. Funeral director

Tos. T Foster

Address

Bel Air, Md19. 4/15

(Date rec'd by registrar)

19 48To Toward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty HartfordCity or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 14 1948 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1948 to April 14 1948and that I last saw her alive on April 14 1948

Immediate cause of death

hypertensionHypertension of kidney

Due to

Due to

Other conditions chr myocardial disease 2 yr

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address

Forest Ave

Date signed

4/15/48

